NHS
Nottingham and Nottinghamshire
Integrated Care Board

Patient Safety Incident Response Policy

October 2024 – September 2027

CONTROL RECORD	
Title	Patient Safety Incident Response Policy
Reference Number	NUR-006
Version	2.0
Status	Final
Author	Assistant Director of Quality & Safety
Sponsor	Deputy Chief Nurse & Director of Quality
Team	Quality Assurance and Quality Intelligence, Nursing & Quality Directorate
Amendments	Sections 5-10 and 12: Wording updated to reflect national policy guidance. Section 11: New section added to reflect national policy guidance. Section 16: Table added to include summarised training requirements.
Purpose	The Patient Safety Incident Response Policy sets out Nottingham and Nottinghamshire Integrated Care Board's approach to fulfilling its roles and responsibilities as defined in the Patient Safety Incident Response Framework: https://www.england.nhs.uk/patient-safety/incident-response-framework/ https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-4.-Oversight-roles-and-responsibilities-specification-v1-FINAL.pdf
Superseded Documents	Patient Safety Incident Response Policy v1.0
Audience	All staff within the NHS Nottingham and Nottinghamshire Integrated Care Board; All ICS partner organisations; Nominated Patient Safety Specialists.
Consulted with	All staff within the NHS Nottingham and Nottinghamshire Integrated Care Board.
Equality Impact Assessment	Reviewed October 2024 (no changes)
Approving Body	Quality and People Committee
Date approved	16 October 2024
Date of Issue	October 2024
Review Date	September 2027
This is a controlled document and whilst this policy may be printed, the electronic version available on the ICB's document management system is the only true copy. As a controlled document, this document should not be saved onto local or network drives.	

NHS Nottingham and Nottinghamshire Integrated Care Board (ICB's) policies can be made available on request in a range of languages, large print, Braille, audio, electronic and other accessible formats from the Engagement and Communications Team at nnicb-nn.comms@nhs.net.

Contents

1. Introduction

1.1. The Patient Safety Incident Response Framework (PSIRF) sets out the NHS approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

1.2. PSIRF replaces the current 'Serious Incident Framework' and is a key component of the NHS patient safety strategy. It is a contractual (mandatory) requirement under the NHS Standard Contract.

1.3. There are four key aims:

- Compassionate engagement and involvement of those affected by patient safety incidents.
- Application of a range of system-based approaches to learning from patient safety incidents.
- Considered and proportionate responses to patient safety incidents.
- Supportive oversight focused on strengthening response system functioning and improvement.

2. Purpose

2.1 The leadership and management functions of the Patient Safety Incident Response Framework (PSIRF) are multifaceted. The PSIRF advocates oversight that enables organisations to demonstrate improvement rather than compliance with prescriptive, centrally mandated measures. To achieve this, oversight of patient safety incident response under PSIRF must focus on engagement and empowerment rather than more traditional command and control.

2.2 This policy sets out Nottingham and Nottinghamshire Integrated Care Board's (NNICB's) approach to fulfilling the roles and responsibility requirements for Integrated Care Boards as defined in the PSIRF:

- Collaborate with providers in the development, maintenance and review of provider patient safety incident response policies and plans.
- Agree provider patient safety incident response policy and plans.
- Oversee and support effectiveness of systems to achieve improvement following patient safety incidents.
- Support co-ordination of cross-system learning responses.
- Share insights and information across organisations/services to improve safety.

3. Scope

3.1 This policy is specific to roles and responsibilities in relation to patient safety incident responses conducted solely for the purpose of learning and improvement across the Nottingham and Nottinghamshire Integrated Care System (NNICS).

3.2 The following principles underpin the oversight of patient safety incident response:

- Improvement is the focus.
- Blame restricts insight.
- Learning from patient safety incidents is a proactive step towards improvement.
- Collaboration is key.
- Psychological safety allows learning to occur.
- Curiosity is powerful.

3.3 Roles and responsibilities under this policy support a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety emerges from interactions and not from a single component. Actions or inactions of people, or 'human error,' are not accepted as the cause of an incident.

3.4 Response types that are outside the scope of this policy include:

- Complaints.
- Human Resources investigations.
- Professional standards investigations.
- Coronial inquests.
- Criminal investigations.
- Claims management.
- Financial investigations and audits.
- Safeguarding concerns.
- Information governance concerns.
- Estates and Facilities issues.
- Any response that seeks to find liability, accountability, or causality.

4. Our Patient Safety Culture

4.1 Open and transparent reporting:

- The ICB both embodies and facilitates an open and transparent reporting of patient safety events, both within the organisation and across the system. The transparency required for a thorough, candid, and systematic approach to learning and improvement is supported by quality governance and oversight mechanisms which are well embedded across the system.
- Staff are encouraged to share and escalate any safety concerns, using Freedom to Speak Up routes and Patient Safety Specialists. Trust Boards and

sub-committees receive regular reports relating to concerns, escalations, challenges, and actions.

- Multidisciplinary meetings take place regularly to review significant incidents based on locally agreed definitions and in the spirit of this transparency these include the ICB Quality and Safety team.

4.2 Development of a just culture

- The ICB both embodies and facilitates a just culture which in line with the NHS guidance promotes:
- '… a consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents.'[1]
- This includes clear and concise guidance to support practitioners and their managers to identify proportionate responses to individual actions, where indicated. It is not intended for routine use in all patient safety incident responses.
- This just culture helps to prevent unconscious bias in decision-making, and protects individuals regardless of their staff group, profession, or background.
- The ICBs just and restorative culture promotes fairness, transparency and learning. This is achieved through acknowledgement that success and mistakes have complex foundations, and through a focus on changing systems and processes so that it is easier for people to do their jobs safely.
- The ICB along with all partners in the system are committed to supporting this as a principle of the NHS People Plan[2] which are reflected in the staff survey questions and built into the standard contract.

5. Patient Safety Partners

5.1 The Patient Safety Partner (PSP) role follows the national guidance and reflects the national PSP role description and with the purpose, training and support needs identified:

- **Purpose:** The ICB PSP will be an active member of key safety governance meetings, including the Partner Quality Assurance and Improvement Group (PQAIG) and the System Quality Group (SQG). See Appendix A for the system quality governance structure, with key meetings highlighted.
- **Training:** As a minimum, training will be provided in information governance; equality, diversity and inclusion; safeguarding level 1; and levels 1 and 2 of the NHS patient safety syllabus.

[1] https://www.england.nhs.uk/wp-content/uploads/2021/02/NHS_0932_JC_Poster_A3.pdf
[2] https://www.england.nhs.uk/ournhspeople/

- **Support needs:** The ICB will co-ordinate and facilitate a network and support forum for the system Patient Safety Partners including those recruited by partner organisations.

6. Addressing Health Inequalities

6.1 Local Patient Safety Incident Response Plans (PSIRPs) reflect the national framework and templates. This ensures a thorough and focused approach to national priorities requiring incident investigation which includes specific groups of people with protected characteristics[3].

6.2 The ICB has a key role to play in tackling health inequalities in partnership with local agencies and services. Fundamental factors such as education, economic and community development, employment levels and housing are contributors to inequalities in healthcare access and outcomes.

6.3 PSIRF requires the utilisation of data and learning from investigations to identify actual and potential health inequalities, supporting recommendations to Board and partner agencies on how to tackle these. This holistic and integrated approach depends on continued collaboration with the patient experience and inclusivity agenda.

6.4 The System Analytical Intelligence Unit (SAIU) enables the ICB to uphold a system-based approach to collection, curation and analysis of data around patient safety and health inequalities.

7. Engaging and Involving Patients, Families and Staff following a Patient Safety Incident

7.1 ICB support for providers.

- Section 5 reflects the ICB approach to supporting the PSPs across the system, providing a restorative network for colleagues in this developing role.
- Engagement with service users is prioritised during investigations with active external reviews and scrutiny, for example Acute Mental Health and Maternity.
- Ongoing support is provided through ICB membership of provider incident response groups and local patient safety committees.

7.2 ICB mechanisms to enable system involvement.

- Section 8 and the table at Appendix A describe how the ICB will ensure collaboration and sharing of learning across the system; Section 10 describes how the ICB will facilitate the approach to cross system responses where multiple providers are involved.

[3] https://www.england.nhs.uk/learning-disabilities/improving-health/learning-from-lives-and-deaths/

- In addition to this, NNICB acknowledges its Duty of Candour and in practice would allocate a named point of contact for an individual or family impacted by a cross system incident.

8. Provider Patient Safety Incident Response Policies and Plans

8.1 Collaboration

- There are strong relationships between the ICB Quality Team and provider partners based on regular informal touchpoint meetings and reciprocal attendance at quality and governance meetings. These relationships enable ongoing discourse around the methodology, outcomes and clarification associated with the development and review of provider PSIRPs.
- Small and Independent Providers: Collaboration with small and independent is facilitated locally by the ICB Quality Assurance Team. Broadly speaking the approach to development of PSIRPs for small and independent providers uses the process map described at Appendix B.
- Local Maternity and Neonatal System: The Nottingham and Nottinghamshire LMNS includes Sherwood Forest Hospitals (SFH) and Nottingham University Hospitals (NUH). Its governance structure is mature with a perinatal quality surveillance model based on the national guidance[4].
- Lead Commissioning Arrangements: Existing quality and governance oversight relationships have supported the collaborative approach to agreement of PSIRPs where NNICB is not the lead commissioner, East Midlands Ambulance Service (lead commissioner Derby and Derbyshire ICB); IMPACT Provider Collaborative (lead commissioner Northamptonshire ICB); Ramsey Healthcare (lead commissioners in London and Lancashire).

8.2 Agreeing policies and plans

- The process for agreeing PSIRPs is described in the flowchart at Appendix C.
- Pre-existing governance arrangements based on the National Quality Board guidelines[5] ensure that partners meet regularly in the system space to discuss existing and emerging quality and safety concerns including themes and trends from incident reviews (see Appendix A).

[4] https://www.england.nhs.uk/wp-content/uploads/2020/12/implementing-a-revised-perinatal-quality-surveillance-model.pdf

[5] https://www.england.nhs.uk/publication/national-guidance-on-quality-risk-response-and-escalation-in-integrated-care-systems/

9. Supporting the Effectiveness of Systems to Achieve Improvement

9.1 Oversight approach:

- The ICB oversight through PSIRF will focus on engagement and empowerment rather than the more traditional command and control.'[6]
- Section 6 and the chart at Appendix A demonstrate an approach which provides regular formal engagement opportunities, strengthened by informal relationships and the encouragement of open and honest behaviours in all settings. This also demonstrates the way in which assurance about quality improvement is reported into the ICB.
- As detailed in Section 7 above, the established precedent for shared review of learning in the LMNS perinatal quality surveillance workstream will continue; and opportunities to apply this approach more widely via the system Patient Safety Specialist network.
- Effectiveness of the local and system quality improvement activities will be monitored through the System Quality Framework and reported via the system quality governance route.

9.2 Resources and training to support oversight:

- See Section 16 for Staff Training.

10. Supporting Cross-System Response

10.1 Relevant safety incidents are identified in agreement with provider partners through Trust level incident response meetings which take place at least weekly.

10.2 Any cross-system responses required are coordinated through existing mechanisms, for example:

a) Clinical Quality Review Group hosted by lead commissioner.

b) Quality Improvement Group established in line with National Quality Board recommendations.

c) Direct contact after incident review to agree shared approach.

10.3 Where independent investigation or other learning response is required, the ICB will work with the NHS Regional Independent Investigation Team as appropriate.

10.4 Where cross-system learning opportunities are identified, for example in relation to shared safety priorities, the ICB will facilitate relevant learning responses including After Action Review or review via existing quality improvement routes.

[6] https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-4.-Oversight-roles-and-responsibilities-specification-v1-FINAL.pdf

11. Supporting High Profile Cases

11.1 The provider level incident review meetings (see paragraph 10.1) provide a robust opportunity for the early recognition and communication of high profile incidents and issues.

11.2 Concise briefings are prepared by the ICB Quality Team when required to enable initial escalation with system and regional stakeholders as required; local communication teams liaise to plan media response.

11.3 Ongoing system oversight and support is agreed with relevant stakeholders and conducted either through existing governance channels or via ad hoc arrangements where required.

12. Sharing Insights to Improve Safety

12.1 The ICS quality governance structure is organised to provide regular opportunities for partners to share and learn, through formal and informal routes.

12.2 The ICS Patient Safety Specialists meet with the NHS England regional team through established arrangements, building a network with peers and developing mechanisms for capturing and sharing insights.

13. Definitions

Term	Definition
Duty of Candour	A professional responsibility to be open and honest with patients and families when something goes wrong.
Oversight	An approach that allows organisations to demonstrate improvement rather than compliance with prescriptive, centrally mandated measures.
Provider	All acute, ambulance, mental health and community healthcare providers who operate under the NHS Standard Contract. Includes small and independent providers of NHS commissioned services.
PSIRF	Patient Safety Incident Response Framework
PSIRP	Patient Safety Incident Response Policy
PSP	Patient Safety Partner – patient, carers or other lay people who support and contribute to a healthcare organisation's governance and management processes for patient safety.
PSS	Patient Safety Specialist – individuals in healthcare organisations (including NHS providers and Integrated Care Boards) who have been designated to provide dynamic senior patient safety leadership.

14. Roles and Responsibilities

Role	Responsibilities
Integrated Care Board (ICB)	• Collaborate with providers in the development, maintenance and review of provider PSIRPs. • Agree provider PSIRPs. • Oversee and support effectiveness of systems to achieve improvement following patient safety incidents. • Support co-ordination of cross system learning responses. Share insights and information across organisations/services to improve safety.
ICB Quality Assurance Team	Co-ordinate the ICB's oversight responsibilities.
ICB Chief Nurse & Medical Director	Provider executive sponsorship for the implementation of PSIRF across Nottingham & Nottinghamshire.

15. Communication, Monitoring and Review

15.1 The policy document is applicable to all staff in the ICB although not directly instrumental to all roles. When ratified it will be communicated to all staff and stored on the intranet for reference. It will be shared on the ICB internet / public facing website in line with the PSIRF requirements.

15.2 The policy will be monitored through the existing PSIRF Implementation Group for its first year, with highlight and exception reporting through the ICB's Quality and People Committee.

15.3 Any individual who has queries regarding the content of this policy or has difficulty understanding how this policy relates to their role, should contact the document author.

16. Staff Training

- Patient Safety Syllabus:

Course	Staff Group/Role	Training Available	Provided By
Level 1a – Essentials for staff	All Staff	ESR E-learning For Health	NHSE
Level 1b – Senior Leaders and Board Members	Senior Leaders and Board Members	ESR E-learning For Health	NHSE
Level 2 – Access to Practice	Staff who will undertake any learning response	ESR E-learning For Health	NHSE

- PSIRF:

Course	Staff Group/Role	Training Available	Provided By
Systems based approaches to incident investigation	Band 7 and above, ICB Quality Team	2 days in person / online self-paced	HSSIB
Involving those affected by patient safety incidents	Band 7 and above, ICB Quality Team	1 day in person / online self-paced	HSSIB
Patient Safety Oversight	Senior Leaders and Board Members in oversight roles Band 8b and above, ICB Quality Team Band 7 ICB Quality Team (optional)	1 day in person / online self-paced	HSSIB

- Notes
  - All PSIRF requirements are covered by Levels 3 & 4 of the Patient Safety Syllabus (provided by Loughborough University).
  - Access to courses may be available in partnership with local providers by arrangement.

17. Equality and Diversity Statement

17.1 NHS Nottingham and Nottinghamshire ICB pays due regard to the requirements of the Public Sector Equality Duty (PSED) of the Equality Act 2010 in policy development and implementation, as a commissioner and provider of services, as well as an employer.

17.2 The ICB is committed to ensuring that the way we provide services to the public and the experiences of our staff does not discriminate against any individuals or groups on the basis of their age, disability, gender identity (trans, non-binary) marriage or civil partnership status, pregnancy or maternity, race, religion or belief, gender or sexual orientation.

17.3 We are committed to ensuring that our activities also consider the disadvantages that some people in our diverse population experience when accessing health services. Such disadvantaged groups include people experiencing economic and social deprivation, carers, refugees and asylum seekers, people who are homeless, workers in stigmatised occupations, people who are geographically isolated, gypsies, Roma and travellers.

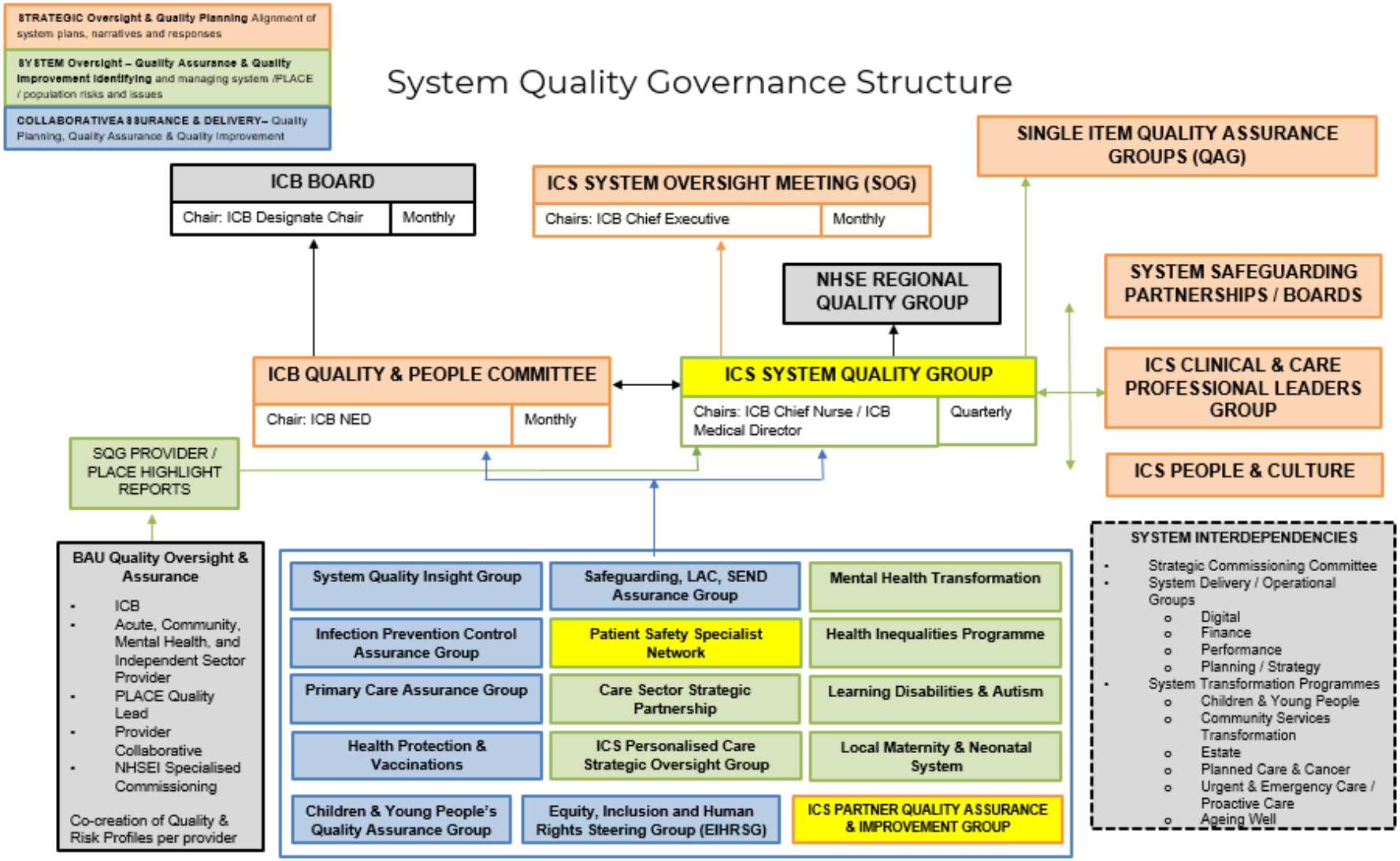
17.4 As an employer, we are committed to promoting equality of opportunity in recruitment, training and career progression and to valuing and increasing diversity within our workforce.

17.5 To help ensure that these commitments are embedded in our day-to-day working practices, an Equality Impact Assessment has been completed for, and is attached to, this policy.

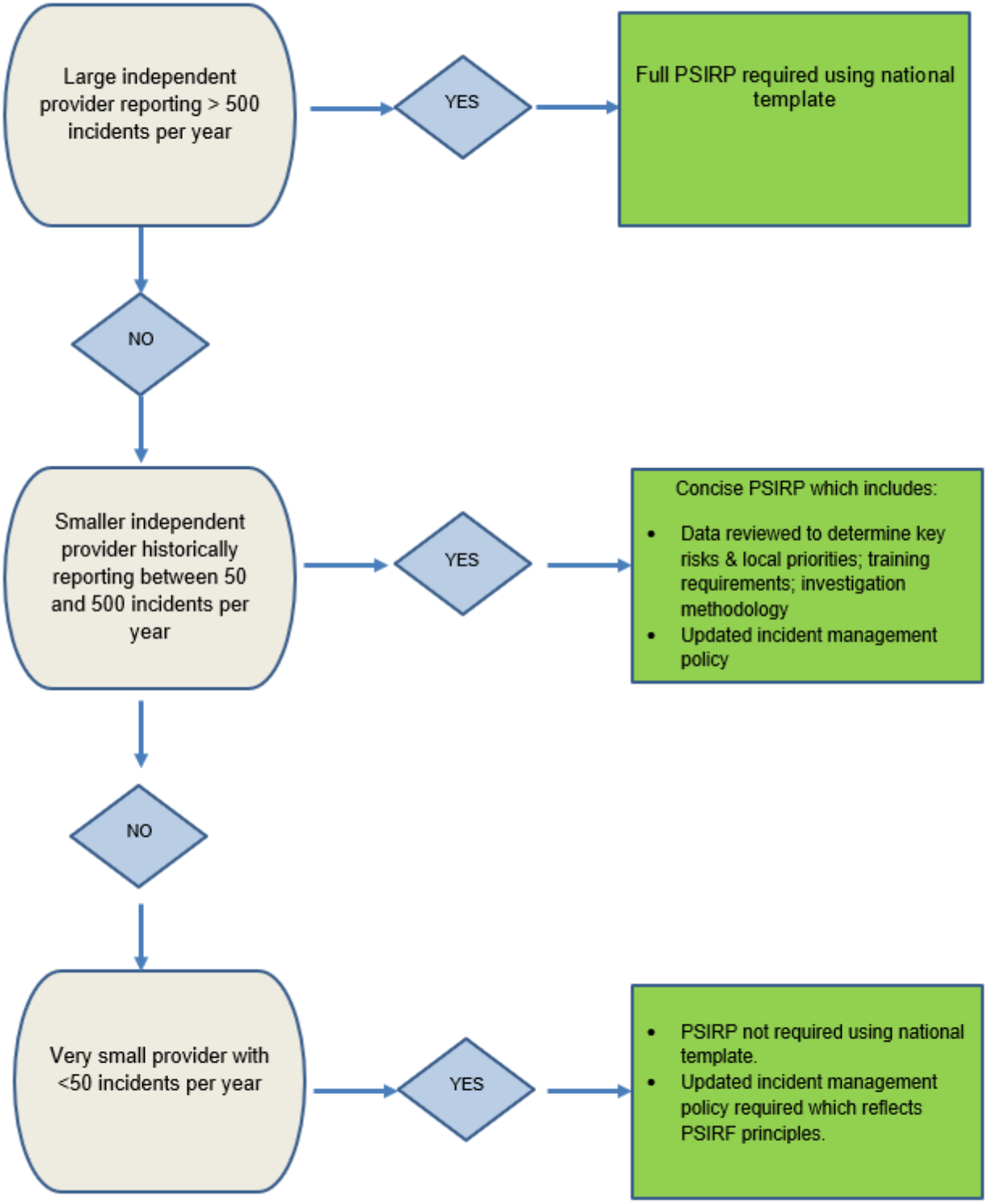
18. Interaction with other Policies

18.1 The relevant national policy documents which support this policy are linked in the footnotes to this document as references.

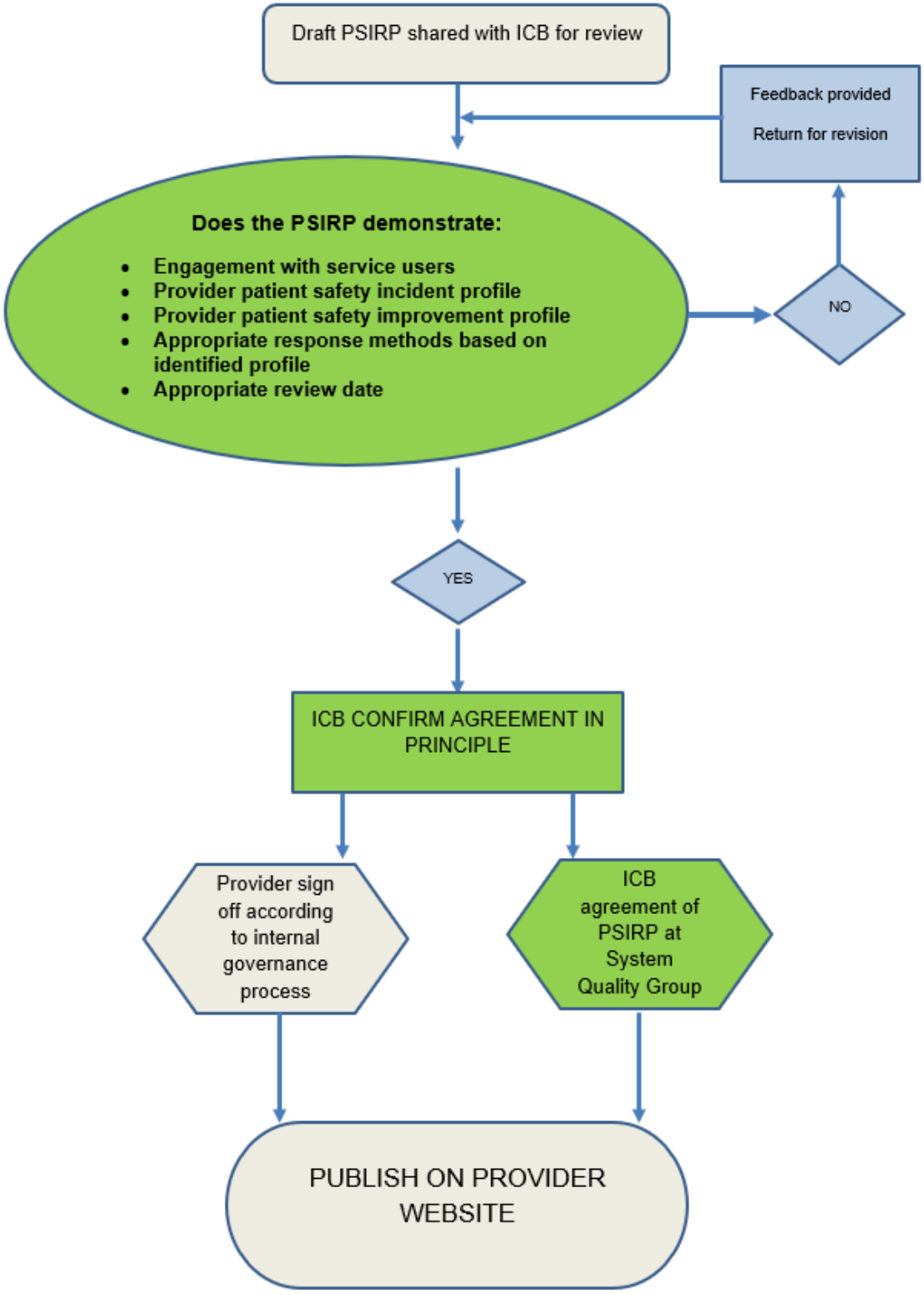
Appendix A: System Quality Governance Structure



Appendix B: Small and Independent Provider PSIRF Process Map



Appendix C: NNICB PSIRP Sign off Process



Appendix D: Equality Impact Assessment

Overall Impact on: **Equality, Inclusion and Human Rights**	**Neutral**

Name of Policy, Process, Strategy or Service Change	Patient Safety Incident Response Policy
Date of Completion	October 2023; reviewed October 2024 for policy update.
EIA Responsible Person Include name, job role and contact details.	Penny Cole, Assistant Director of Quality & Safety, NNICB Email: penny.cole@nhs.net
Wider Consultation Undertaken State who, outside of the project team, has been consulted around the EIA.	Staff Engagement Group; NNICB EDI Lead
Summary of Evidence Provide an overview of any evidence (both internal and external) that you utilised to formulate the EIA. E.g., other policies, Acts, patient feedback, etc.	Equality Act 2010; NNICB Policy for Development and Management of Policy Documents; NHSE National Patient Safety Framework template documents

	What are **the actual, expected or potential positive impacts** of the policy, process, strategy or service change?	What are the **actual, expected or potential negative impacts** of the policy, process, strategy or service change?	What **actions have been taken** to address the actual or potential **positive and negative impacts** of the policy, process, strategy or service change?	**Impact Score**
Age	The policy is universal to all patient groups and providers of NHS commissioned services.	No negative impacts are anticipated from the introduction of this policy.		**3 - Neutral**
Disability[1] (Including: mental, physical, learning, intellectual and neurodivergent)	The policy is universal to all patient groups and providers of NHS commissioned services.	The ICB should ensure that a version of the Policy is produced to allow screen readers and dictation software to read the document more easily. Screen readers find tables difficult to read, making the document less accessible to people who use this or similar technology.	NHS Nottingham and Nottinghamshire ICB's policies can be made available, on request, in a range of languages and formats from our Engagement and Communication Team via nnicb-nn.comms@nhs.net	**3 - Neutral**

Gender[2] (Including: trans, non-binary and gender reassignment)	The policy is universal to all patient groups and providers of NHS commissioned services.	No negative impacts are anticipated from the introduction of this policy.		**3 - Neutral**
Marriage and Civil Partnership	The policy is universal to all patient groups and providers of NHS commissioned services.	No negative impacts are anticipated from the introduction of this policy.		**3 - Neutral**
Pregnancy and Maternity Status	The policy is universal to all patient groups and providers of NHS commissioned services.	No negative impacts are anticipated from the introduction of this policy.		**3 - Neutral**
Race[3]	The policy is universal to all patient groups and providers of NHS commissioned services.	Access to the policy for those without English as first language.	NHS Nottingham and Nottinghamshire ICB's policies can be made available, on request, in a range of languages and formats from our Engagement and Communication Team via nnicb-nn.comms@nhs.net	**3 - Neutral**
Religion and Belief[4]	The policy is universal to all patient groups and providers of NHS commissioned services.	No negative impacts are anticipated from the introduction of this policy.		**3 - Neutral**

Sex[5]	The policy is universal to all patient groups and providers of NHS commissioned services. As a new policy, an evaluation period is required to measure actual impacts, therefore this is assessed as neutral until the policy is updated.	No negative impacts are anticipated from the introduction of this policy.		**3 - Neutral**
Sexual Orientation[6]	The policy is universal to all patient groups and providers of NHS commissioned services.	No negative impacts are anticipated from the introduction of this policy.		**3 - Neutral**
Human Rights[7]	The policy is universal to all patient groups and providers of NHS commissioned services.	No negative impacts are anticipated from the introduction of this policy.		**3 - Neutral**
Community Cohesion and **Social Inclusion**[8]	The policy is universal to all patient groups and providers of NHS commissioned services.	No negative impacts are anticipated from the introduction of this policy.		**3 - Neutral**

Safeguarding[9] (Including: adults, children, Looked After Children and adults at risk or who lack capacity)	The policy is universal to all patient groups and providers of NHS commissioned services.	No negative impacts are anticipated from the introduction of this policy.		**3 - Neutral**
Other Groups at Risk[10] of Stigmatisation, Discrimination or Disadvantage	The policy is universal to all patient groups and providers of NHS commissioned services.	No negative impacts are anticipated from the introduction of this policy.		**3 - Neutral**

Positive Impact	Neutral Impact	Undetermined Impact	Negative Impact
52 to 46	**45 to 33**	**32 to 20**	**19 to 13**

Additional Equality Impact Assessment Supporting Information

1. **Disability** refers to anyone who has: "…a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on your ability to do normal daily activities…" (Equality Act 2010 definition). This includes, but is not limited to: mental health conditions, learning disabilities, intellectual disabilities, neurodivergent conditions (such as dyslexia, dyspraxia and dyscalculia), autism, many physical conditions (including HIV, AIDS and cancer), and communication difficulties (including d/Deaf and blind people).

2. **Gender**, in terms of a Protected Characteristic within the Equality Act 2010, refers to: "A person has the protected characteristic of gender reassignment if the person is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex."

3. **Race**, in terms of a Protected Characteristic within the Equality Act 2010, refers to: A person's colour, nationality, or ethnic or national origins. This also includes people whose first spoken language is not English, and/or those who have a limited understanding of written and spoken English due to English not being their first language.

4. **Religion and Belief**, in terms of a Protected Characteristic within the Equality Act 2010, refers to: Religion means any religion and a reference to religion includes a reference to a lack of religion. Belief means any religious or philosophical belief and a reference to belief includes a reference to a lack of belief.

5. **Sex**, in terms of a Protected Characteristic within the Equality Act 2010, refers to: A reference to a person who has a particular protected characteristic and is a reference to a man or to a woman.

6. **Sexual Orientation**, in terms of a Protected Characteristic within the Equality Act 2010, refers to: Sexual orientation means a person's sexual orientation towards persons of the same sex, persons of the opposite sex or persons of either sex.

7. The **Human Rights Act 1998** sets out the fundamental areas that everyone and every organisation must adhere to. In relation to health and care, the most commonly applicable of the Articles within the Human Rights Act 1998 include: Article 2 Right to Life, Article 5 Right to Liberty and Security, Article 8 Right to Respect of Private and Family Life, and Article 9 Freedom of Thought, Conscience and Religion.

8. **Community Cohesion** is having a shared sense of belonging for all groups in society. It relies on criteria such as: the presence of a shared vision, inclusion of those with diverse backgrounds, equal opportunity, and supportive relationships between individuals. **Social Inclusion** is defined as the process of improving the terms of participation in society, particularly for people who are disadvantaged, through enhancing opportunities, access to resources, voice and respect for rights (United Nations definition). For the EQIA process, we should note any positive or negative impacts on certain groups being excluded or not included within a community or societal area. For example, people who are homeless, those from different socioeconomic groups, people of colour or those from certain age groups.

9. **Safeguarding** means: "…protecting a citizen's health, wellbeing and human rights; enabling them to live free from harm, abuse and neglect. It is an integral part of providing high-quality health care. Safeguarding children, young people and adults is a collective responsibility" (NHS England definition). Those most in need of protection are children, looked after children, and adults at risk (such as those receiving care, those under a DoLS or LPS Order, and those with a mental, intellectual or physical disability). In addition to the ten types of abuse set out in the Health and Care Act 2022, this section of the EQIA should also consider PREVENT, radicalisation and counterterrorism.

10. **Other Groups** refers to anyone else that could be positively or negatively impacted by the policy, process, strategy or service change. This could include, but is not limited to: carers, refugees and asylum seekers, people who are homeless, gypsy, Roma and traveller communities, people living with an addiction (e.g., alcohol, drugs or gambling), people experiencing social or economic deprivation, and people in stigmatised occupations (e.g., sex workers).